Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: BAYLOR SURGICAL HOSPITAL/FT WORTH 750 13TH AVENUE FORT WORTH TEXAS 76104	MFDR Tracking #: M4-09-5477-01
Respondent Name and Box #: AMERICA FIRST LLOYDS INSURANCE CO REP BOX #: 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on Appeal letter dated 11/10/08 states in part: "The following claim was not processed according to Texas fee guidelines for outpatient services…As of March 1, 2009, TDI Rule §134.403; subsection (g) implantables shall be reimbursed at the lesser of manufacturer's invoice amount plus an add-on of 10percent or $1000.00 per billed item, whichever is less, but not to exceed $2,000.00 per admission…This claim involved implants. We are requesting separate payment of the cost of implants plus 10% as indicated in these guidelines…We have included the claim, itemized bill, medical records and EOB which reflects the payment of $9,271.19. Our office is requesting additional reimbursement per TID Rule 134.403(f)(1) in the amount of $2,830.71…"

Principle Documentation:

1. DWC 60 package
2. Hospital or Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought $2,830.71

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "…The billing in dispute has been paid at a fair and reasonable rate in accordance with DWC guidelines, policies and rules, and the Texas Labor Code. Carrier has determined that $9,271.19 represents an amount greater than or equal to the fair and reasonable reimbursement for this service…Carrier has calculated reimbursement based on a fair and reasonable standard…"

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Services in Dispute	Calculation	Amount in Dispute	Amount Due
08/15/2008 thru 08/16/2008	Hospital Outpatient Services	$4,160.96 (APC) + $0.00 (Fee Schedule) + $0.00 (Outlier Amount) = $4,160.96 (OPPS) x 130% = $5,409.25 + $6,692.29 (Total cost of implants x 10%) = $12,101.54 - $9,271.19 (Total paid by Respondent) = $2,830.35.	$2,830.71	$2,830.35
			Total Due:	$2,830.35

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule §134.403, titled ***Hospital Facility Fee Guideline – Outpatient,*** effective for medical services provided on or after March 1, 2008, set out the reimbursement guidelines for Hospital outpatient services.

This dispute was filed in the form and manner as prescribed by 28 TAC §133.307 and is eligible for Medical Dispute Resolution under 28 TAC §133.305 (a)(4).

1. The services listed in Part IV of this decision were denied or reduced by the Respondent with the following reason codes:
   Explanation of benefits with the listed date of audit 10/15/2008
   - W1 — Workers Compensation State Fee Schedule Adjustment. Fee Guideline AMR Reduction.
   - 97 — Pymt adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Payment included in APC rate per the TX Hospital Medicare Methodology per Rule 134.403(D).

   Explanation of benefits with the listed date of 11/26/2008
   - W4 — No additional reimbursement allowed after review of appeal/reconsideration
2. Rule 134.403 (e) states in pertinent part, "Regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;…"
3. Pursuant to Rule 134.403(f), "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 200 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.
4. Upon review of the documentation submitted by the requestor and respondent, the Division finds that:
   (1) No contract exists;
   (2) MAR can be established for these services; and
   (3) Separate reimbursement for implantables *WAS* requested by the requestor.
5. Consequently, reimbursement will be calculated in accordance with Rule §134.403 (f)(1)(A) as follows:

APC Value	Fee Sch	Outlier Payment	Separate Reimbursement for implantables WAS requested under Rule §134.403	APC + Fee Schedule + Outlier Payment X 130%	Subtract Amount Paid by Respondent	Results in additional Amount Due to Requestor
$1,797.93	$0.00	$0.00	$6,083.90 (Total cost of implants) x 10% = 6,692.29	$4,160.96	$9,271.19	$2,830.35

6. Based upon the documentation submitted by the parties and in accordance with Texas Labor Code Sec. 413.031 (c), the Division concludes that the requestor, Baylor Surgical Hospital/Fort Worth, is not due additional payment. As a result, the amount ordered is $2,830.35.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 TAC Rule §134.403
28 TAC Rule §133.307
28 TAC Rule §133.305

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby ORDERS the Carrier to remit to the Requestor the amount of $2,830.35 plus accrued interest per Rule 134.130 due within 30 days of receipt of the Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	October 6, 2009 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.